Med Rec – Whose Responsibility is it Anyway?
Making the MAP Multidisciplinary

Deb Miller & Ann Whitaker
Redland Hospital, Cleveland QLD
History of MAP at Redland

- One of the QH pilot sites in 2005
  - MAP (in various forms) has been around for at least 9 years
- High 5s in 2010
  - Extra ‘ammunition’ to promote use
- 90-95% of patients admitted have a MAP/BPMH
  - Fast turnaround times can be problematic
- Incorporated into eLMS software program
  - Used to generate other records
MAP/eLMS Also Used For:

- Discharge medication reconciliation
  - Inpatient/Leave/Discharge Medication Record
  - Interim Medication Administration Record
- Pre-Admission Clinic
  - Pre-admission Medication Record
    → NIMC
- Renal Dialysis Unit
  - Outpatient Medication Record
# eLMS (Enterprise Liaison Medication System)

## Episode of Care

### Admission Details
- **UR Number:** R599999
- **First Name:** Santa
- **Surname:** Claus
- **Sex:** M
- **DOB:** 24/12/1900

Created at 29/10/2013 2:05:26 PM by Fielding, Kerry
Modified at 30/10/2014 4:07:47 PM by Whittaker, Ann

### Admission Medications

<table>
<thead>
<tr>
<th>New Medicine</th>
<th>Generic Medicine</th>
<th>Strength</th>
<th>Form</th>
<th>Route</th>
<th>Dose &amp; Direction</th>
<th>Additional Directions</th>
<th>Change</th>
<th>Trade Name</th>
<th>Delete</th>
</tr>
</thead>
<tbody>
<tr>
<td>Select to Move Sodium Valproate</td>
<td></td>
<td>200mg</td>
<td>EC TAB</td>
<td>Oral</td>
<td>1 bd</td>
<td></td>
<td></td>
<td>Eptilim</td>
<td>DELETE</td>
</tr>
<tr>
<td>Select to Move Sodium Valproate</td>
<td></td>
<td>500mg</td>
<td>EC TAB</td>
<td>Oral</td>
<td>1 bd</td>
<td></td>
<td></td>
<td>Eptilim</td>
<td>DELETE</td>
</tr>
<tr>
<td>Select to Move Olanzapine</td>
<td></td>
<td>5mg</td>
<td>Tablets</td>
<td>Oral</td>
<td>1 m</td>
<td></td>
<td></td>
<td>Zyprax</td>
<td>DELETE</td>
</tr>
<tr>
<td>Select to Move Esomeprazole</td>
<td></td>
<td>40mg</td>
<td>Tablets</td>
<td>Oral</td>
<td>1 m</td>
<td></td>
<td></td>
<td>Medium</td>
<td>DELETE</td>
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<tr>
<td>Select to Move Olanzapine</td>
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<td>10mg</td>
<td>Tablets</td>
<td>Oral</td>
<td>1 m</td>
<td></td>
<td></td>
<td>Zyprax</td>
<td>DELETE</td>
</tr>
<tr>
<td>Select to Move Levothyroxine</td>
<td></td>
<td>100 microgram</td>
<td>Tablets</td>
<td>Oral</td>
<td>1 m</td>
<td>Dose given at 1700</td>
<td></td>
<td>Levoxin</td>
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<tr>
<td>Select to Move Clopidogrel</td>
<td></td>
<td>75mg</td>
<td>Tablets</td>
<td>Oral</td>
<td>1 m</td>
<td></td>
<td></td>
<td>Iscover</td>
<td>DELETE</td>
</tr>
<tr>
<td>Select to Move Furosemide - Feow ac</td>
<td></td>
<td>250mg-0.2mg</td>
<td>OR TAB</td>
<td>Oral</td>
<td>1 m</td>
<td></td>
<td></td>
<td>FGF</td>
<td>DELETE</td>
</tr>
<tr>
<td>Select to Move Metformin</td>
<td></td>
<td>1g</td>
<td>Tablets</td>
<td>Oral</td>
<td>1 bd</td>
<td></td>
<td></td>
<td>Prandin</td>
<td>DELETE</td>
</tr>
<tr>
<td>Select to Move Aspirin</td>
<td></td>
<td>100mg</td>
<td>Capsules</td>
<td>Oral</td>
<td>1 m</td>
<td></td>
<td></td>
<td>Aspirin</td>
<td>DELETE</td>
</tr>
<tr>
<td>Select to Move Paracetamol</td>
<td></td>
<td>500mg</td>
<td>Tablets</td>
<td>Oral</td>
<td>1 - 2 tid pm</td>
<td></td>
<td></td>
<td>Dymadon P</td>
<td>DELETE</td>
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<tr>
<td>Select to Move LOPERAMIDE HYDROCHLORIDE</td>
<td></td>
<td>2mg</td>
<td>Capsules</td>
<td>Oral</td>
<td>1 tid pm</td>
<td>Maximum dose of 2 per night.</td>
<td></td>
<td>Gastro-Stop Loperamide</td>
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</tr>
<tr>
<td>Select to Move Decoate - Xanax</td>
<td></td>
<td>50mg/5mg</td>
<td>Tablets</td>
<td>Oral</td>
<td>1 - 2 tid pm</td>
<td>Maximum dose of 2 per night.</td>
<td></td>
<td>Coloxyol and zones</td>
<td>DELETE</td>
</tr>
<tr>
<td>Select to Move LOPERAMIDE HYDROCHLORIDE</td>
<td></td>
<td>2mg</td>
<td>Capsules</td>
<td>Oral</td>
<td>1 tid</td>
<td></td>
<td></td>
<td>Gastro-Stop Loperamide</td>
<td>DELETE</td>
</tr>
<tr>
<td>Select to Move Norfloxacin</td>
<td></td>
<td>400mg</td>
<td>Tablets</td>
<td>Oral</td>
<td>1 bd</td>
<td></td>
<td></td>
<td>Stopped - Ceased</td>
<td>DELETE</td>
</tr>
<tr>
<td>Select to Move Timolol</td>
<td></td>
<td>500mg</td>
<td>Tablets</td>
<td>Oral</td>
<td></td>
<td>Take FOUR tablets as a single...</td>
<td></td>
<td>Stopped - Ceased</td>
<td>DELETE</td>
</tr>
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</table>

### Admission G/F/L/Hx

<table>
<thead>
<tr>
<th>Medication</th>
<th>Route</th>
<th>Dose</th>
<th>Change</th>
<th>Trade Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eptilim</td>
<td></td>
<td></td>
<td></td>
<td>Eptilim</td>
</tr>
<tr>
<td>Eptilim</td>
<td></td>
<td></td>
<td></td>
<td>Eptilim</td>
</tr>
<tr>
<td>Zyprax</td>
<td></td>
<td></td>
<td></td>
<td>Zyprax</td>
</tr>
<tr>
<td>Medium</td>
<td></td>
<td></td>
<td></td>
<td>Medium</td>
</tr>
<tr>
<td>Zyprax</td>
<td></td>
<td></td>
<td></td>
<td>Zyprax</td>
</tr>
<tr>
<td>Levoxin</td>
<td></td>
<td></td>
<td></td>
<td>Levoxin</td>
</tr>
<tr>
<td>Iscover</td>
<td></td>
<td></td>
<td></td>
<td>Iscover</td>
</tr>
<tr>
<td>FGF</td>
<td></td>
<td></td>
<td></td>
<td>FGF</td>
</tr>
<tr>
<td>Prandin</td>
<td></td>
<td></td>
<td></td>
<td>Prandin</td>
</tr>
<tr>
<td>Aspirin</td>
<td></td>
<td></td>
<td></td>
<td>Aspirin</td>
</tr>
<tr>
<td>Dymadon P</td>
<td></td>
<td></td>
<td></td>
<td>Dymadon P</td>
</tr>
<tr>
<td>Gastro-Stop Loperamide</td>
<td></td>
<td></td>
<td></td>
<td>Gastro-Stop Loperamide</td>
</tr>
<tr>
<td>Coloxyol and zones</td>
<td></td>
<td></td>
<td></td>
<td>Coloxyol and zones</td>
</tr>
<tr>
<td>Stopped - Ceased</td>
<td></td>
<td></td>
<td></td>
<td>Stopped - Ceased</td>
</tr>
<tr>
<td>Stopped - Ceased</td>
<td></td>
<td></td>
<td></td>
<td>Stopped - Ceased</td>
</tr>
</tbody>
</table>

### Recommendations

- Take FOUR tablets as a single dose.

### Communication History

- Open Charts, Forms and Letters

### Medication Action Plan

- Save
- Close
**Interim Medication Administration Record**

- **URN**: R999999
- **Family Name**: Claus
- **Given Names**: Santa
- **Address**: 3 Jingle Bell Lane North Pole
- **Date of Birth**: 24/12/1900
- **Sex**: M

**Documented by:**
- **Signature**: [Blank]
- **Name**: [Blank]
- **Designation**: [Blank]
- **Date**: [Blank]

**Counter signed by (if required):**
- **Signature**: [Blank]
- **Name**: [Blank]
- **Designation**: [Blank]
- **Date**: [Blank]

**Medications taken prior to presentation to hospital:**
- **Warfarin Variable Dose Tablets (Marvarin) / Oral**
- **Take 3mg tablets in the EVENING**

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**Redland Hospital Pharmacy Department**

**Mr Santa Claus**  
**UR: R999999  DOB: 24 Dec 1900**

**Discharge Medication Record: 30 Oct 2014**

**Ward:** [Blank]

If you have any questions, please phone (07) 3488 3134

**Medicine Names**

<table>
<thead>
<tr>
<th>Used for</th>
<th>Directions</th>
<th>Morning</th>
<th>Noon</th>
<th>Evening</th>
<th>Night</th>
<th>Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevent heart attacks and strokes</td>
<td>Take 1 tablet in the MORNING with food <em>Packed</em></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevent heart attacks, strokes, lowers cholesterol</td>
<td>Take 1 tablet at NIGHT <em>Packed</em></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treat angina, chest pain</td>
<td>Dissolve 1 tablet under the tongue when required</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Allergies and Adverse Drug Reactions:**

- **Date**: 26/11/2013
  - **Medicine / Causal Agent**: Penicillin
  - **Reaction**: Anaphylaxis

- **Date**: 20/11/2013
  - **Medicine / Causal Agent**: Cephalexin & Cephradine
  - **Reaction**: Anaphylaxis with penicillin

**Authorised by**: Ann Whitaker (Pharmacist)
Where We’re At Now

• BPMH documented predominantly by pharmacists (& Deb!)
  – If done in ED → basis for NIMC

• Issues documented by multidisciplinary team

• Issues ‘answered’
  – Generally requires prompting: “See MAP”
### Multidisciplinary MAPping

<table>
<thead>
<tr>
<th>Issue Identified</th>
<th>Proposed Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Miconazole No cream for groin</td>
<td>To discontinue plain?</td>
</tr>
<tr>
<td></td>
<td>Clear, no sign of infection, no rash</td>
</tr>
<tr>
<td>Issue identified by:</td>
<td>Contact number:</td>
</tr>
</tbody>
</table>

Pt. due for tel end of the week - requires new webster

<table>
<thead>
<tr>
<th>Issue identified by:</th>
<th>Contact number:</th>
</tr>
</thead>
</table>

How can this be facilitated?

<table>
<thead>
<tr>
<th>Pt's Blood pressure recording high on daily obs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please review.</td>
</tr>
</tbody>
</table>

| Issue identified by: | Contact number: |

Pt standing in urine pellets tomorrow

| Issue identified by: | Contact number: |

Are there any interactions with current meds

| Issue identified by: | Contact number: |

Trouble swallowing tablets > needn't crushed please

| Issue identified by: | Contact number: |

Redland Hospital
Where We’d Like To Be At

- BPMH contributed to by all staff, even if it’s just:
How have we gotten there?
Medical & Nursing Orientations/Competency Training

Avoid Post-It culture

Raise any issues you have on the MAP

Beneficial just to get the process started

It is a Best Possible Medication History

Document result of action
Nursing Pioneers - 2011

• One day training
• 10 ED RNs
• MSQ & local resources
  • Modules & case studies
- MSQ BPMH video
- How to MAP/Reconcile
- Lillian & Bruce
- Common BPMH Traps
- Medication resources
- Role plays
- Supervised practice: Wards & ED
- Competency assessment
Nursing Pioneer Feedback

Good being able to discuss as we go along

Was good to see how to put things into practice

Really fun

Situations stick in head, as it gives you a scenario to remember

Errors are a reality. Need to minimise. MAP a very useful tool

Very important for patient safety

Understanding real situations & real problems

Case scenarios always ‘hit home’

But has this changed practice?...
Jumping on Every Promotional Opportunity

• Grand Rounds
  – Lillian & Bruce
• Departmental business meetings
• Posters, badges, stickers, window displays…
DOCTORS

Your patient needs you to:
- list the BPMH
- document intentional changes
- review issues daily
Update from the Executive team with Julieanne Graham, Deputy Director Medical Services

**Redland Hospital High Fivers Set High Standards**

Redland Hospital has joined forces with the WHO and hospitals around the world to address patient safety issues regarding medication. The Hospital is one of only 28 Australian hospitals selected (from 1500) to take part in the World Health Organisation’s (WHO) medication initiative, which is part of the WHO High 5s Project. The High 5s Project 2005 to address continuing major concerns about patient safety around medication errors and preventable adverse drug events.

The countries that initiated the High 5s Project were Australia, Canada, Germany, the Netherlands, New Zealand, the United Kingdom, and the USA. Health ministers and leaders of six of these countries formally endorsed the project in 2003. France, Saudi Arabia, and Singapore have subsequently joined the project.

Five standardised operating protocols (SOPs) have been developed to support the project. These SOPs address:

1. **Concentrated injectable medicines**
2. **Medication accuracy at transitions in care**
3. **Correct procedure at the correct bedside**
4. **Communication failures during patient handovers**
5. **Addressing health care-associated infections**

Redland Hospital is working with the second SOP, medication accuracy at transitions in care. The Redland High 5s Team is a multidisciplinary team consisting of nurses, pharmacists, doctors, and the quality coordinator. An initial audit of medication charts conducted in November 2011 provided baseline statistics that identified 2.5 percent of admitted patients, aged over 65, with unintentional discrepancies in their charted medication orders. An audit of admission medications, international research has shown that between 10 to 57 percent of medication histories may contain at least one error.

**What is the MAP form?**

The MAP should be the primary reference point for all medication management. The MAP allows clinical handover of medication management

- **Admission:** facilitates taking a BPHM and reconciliation (MATCHED UP) with the medication chart.
- **Daily review:** facilitates reconciliation and safe discharge.
- **Discharge:** facilitates reconciliation of BPHM with discharge medication orders, thus providing an accurate discharge reconciliation record.

The MAP form is kept in the patient’s bedside folder with the medication chart so all clinicians have easy access. It is intended as a tool for daily use to improve patient care and planning for discharge.

Redland Hospital to pilot MAP in 2011. Redland Hospital has been chosen as a pilot site in Australia. Whether an event is resolved within 48 hours of initial documentation is an area where results can significantly improve, with medication reconciliation taking more than 48 hours to document on the MAP significantly affects discharge times, bed block, and patient flow.
Community pharmacists: we need your help to improve patient safety!

What are we doing to MATCH UP patient medicines?

On admission to hospital
1. A clinical team member interviews the patient and lists all medications they are using.
2. A second source (such as pharmacy) is used to confirm, correct, and as completed to scrutinise the patient’s own medication list.
3. The medication history is documented in the inpatient medication chart.

On discharge from hospital
1. The patient’s discharge plan includes their current medications and any changes made.
2. A copy of the discharge medication list is provided to the patient’s GP and community pharmacy on request.

Research has shown that, internationally, between 10% and 57% of medication histories contain at least one error. These errors hold significant potential for patient harm. Medication matching has been shown to decrease errors from 213 to 60 per 100 admissions.

Redland and Wynnum Hospital values patient safety and we are working to ensure that both you and your staff are familiar with these medication errors by implementing strategies to improve medication safety.


To our patients

We encourage you to take the time to ensure your medicine list is up-to-date for the new year.

This will help you to be medicinewise and help us to MATCH UP medicines.

Merry Christmas and a Happy New Year from the Redland Hospital Pharmacy

Are you going into hospital? What you need to know about your medicines

If you are going into hospital, you can help the hospital staff to increase the benefits and reduce the risk associated with your medicines. Your hospital doctor, nurse, and pharmacist need to know what you are taking. Staff also need to know about any recent changes to your medicines. This includes over-the-counter, natural, and herbal remedies that you buy without a prescription.

You arrive at the hospital
1. On arrival at the hospital it is important to tell the staff about all the medicines you are taking and any changes to your medicines. You may be asked this more than once during your stay to make sure any changes have been missed. Show your up-to-date medicine list and give your own medicines to the staff to check.
2. ONG UP your medicines is checking what medicines you were taking before admission to the hospital, compared to what is prescribed during your hospital stay. This makes sure that you receive the medicines, at the right dose, and at the right time, while you are in hospital.

Why it is essential to MATCH UP your medicines

MATCHING UP can prevent unintentional changes to your medicines during hospital admissions. Unintentional changes can prolong your stay in hospital, or even cause you harm.

How you can help

When you go into hospital, please draw staff attention to your up-to-date medicine list and all your medicines, including their original labelled containers where possible. Your community pharmacist or family doctor can help you to make this list. Your medicine list should include all your medicines, including medicines from pharmacies, supermarkets, health food shops, and alternative therapists.

For example:

- prescription medicines
- vitamins and minerals
- over-the-counter medicines
- natural or herbal remedies (sometimes called complementary or alternative medicines)
- creams or ointments
- eye drops and eye ointments
- inhalers and sprays
- patches
- pessaries or suppositories
- injections

Santa’s list is up-to-date... Is yours??
Theory vs Reality: Do Perceived Clinical Improvement Processes Make a Difference? Part 2: Discharge from Hospital

Metro South Health
Gabrielle Lambert, Susan Cottrell, Kerry Felitag, Eleanore Humphreys, Greg Spann, Michelle Stone
Redland Hospital Pharmacy

AIM
To determine the impact of a number of quality improvement processes in regards to the continuity of care for patients discharged from hospital. These initiatives are in accordance with National and International safety recommendations such as Australian/Pharmaceutical Advisor Council guiding principles to achieve continuity in medication management.

METHOD
a) Participation in state-wide performance indicators of discharge Medication Administration Record (MAR) provided for non-same-day separations.
b) Monitor the accuracy of the MAR utilizing a state-wide audit.
c) Implementation of an Intern Medication Administration Record (MAR) for discharges from Financial aged Care Facilities (RACF).
d) Survey local General Practitioners (GPs) regarding the timeliness, content and preference of discharge summaries.

RESULTS
a) Average percentage of MAR completed on or within 1 month was 59% which exceeded the state-wide median of 25%.
b) The quality audit demonstrated that MARs were both comprehensive and accurate, with minimal major discrepancies.
c) Initial results to date indicate that 100% of pharmacists would like the MAR to be provided to all RACF and RACF staff actively sought further initiatives.

The survey indicated the average MAR completion time was 5.1 days after discharge, and is reconsidered another 2 days after discharge, and is reconsidered another 2 days after discharge, depending on whether the patient was present in person or electronically. Only 36.4% of MARs that had received a discharge summary within the preferred 2 days. Summaries received beyond that time potentially increase the risk for medication mismanagement.

CONCLUSION
The results of this study indicate in relation to medication discrepancies weekly management as an imperative to the provision of optimum health care. Despite comprehensive MARs being provided for the majority of patients prescribed medicines and not always reaching the MARs a timely manner via the DS system, further review of systems to improve the continuous care.

References/Acknowledgements
1. Australian Commission on Safety and Quality in Health Care.

Best Possible Medication History on Admission

Metro South Health
Ann Whitaker1, Gabrielle Lambert1, Deborah Miller2
1Redland Hospital Pharmacy; 2Redland Hospital Emergency

AIM
To provide impact data for quality improvement processes for hospital admissions. These pharmacy-based initiatives are undertaken to meet patient safety recommendations such as from the World Health Organization (WHO) and Australian Pharmaceutical Advisor Council (APAC).

METHOD
a) The WHO Higher Initiative’s performance measure “MAR” showed medication reconciliation rates within 24 hours of admission. Strategies to improve this measure included “Medication Action Plan” and “best practice medication history” form training to medical and nursing “prerequisite”.

RESULTS
a) In June 2014, 46.3% of admissions aged 46 and above had medication reconciliation performed within 24 hours of admission, whereas in December 2014 the figure reduced to 4.6%. Removing the data for weekend admissions (as these times were often missed) improves these figures to 50% and 70%, respectively. Despite ongoing promotion “MAR” rates remain poor especially in the introduction of a Saturday Clinical Pharmacist service in June 2013 which has thus far has significantly improved weekend “MARs”. This indicates that the processes remain pharmacy-driven and a broader multidisciplinary cultural change is required for any significant improvement.

b) At 44%, the majority of “MAR” discrepancies were classified into the NIC N/CES Criteria D2: “An error occurred that the patient and the patient not continuing to monitor or confirming it to result in no harm to the patient and no required interventions proceed/held”. The most common example of these were discrepancies in antihypertensive drugs. These discrepancies may disrupt discharge patient flow and medication, contribute to patient dissatisfaction and confusion could cause an adverse drug event if continued post-discharge.

CONCLUSION
Medication reconciliation within 24 hours of admission has been widely recognized as imperative to the provision of optimum health care. Discrepancies, occurring frequently over time, are difficult to identify and often driven by Drug Services Pharmacy. Further study is ongoing to identify additional areas for improvement.

References/Acknowledgements
BE MEDICINEWISE
Take the medicinewise challenge

1. KNOW THE ACTIVE INGREDIENTS IN YOUR MEDICINES
   Every medicine has an active ingredient that makes it work.
   Find the active ingredient name printed on your medicines to make sure you’re not doubling up.

2. MAKE A MEDICINES LIST
   Keep track of your medicines with an NPS Medicines List.
   List all of your prescription, over-the-counter and complementary medicines and share the list with everyone involved in your healthcare.

3. CLEAN OUT YOUR MEDICINES CABINET
   Medicines can come in many forms. Do you know how many are lying around your house?
   Spring clean your medicines cabinet today and return your out-of-date or unwanted medicines to any pharmacy for safe disposal.

4. FOLLOW MEDICINES INSTRUCTIONS
   Medicines instructions are important but they can sometimes be hard to follow.
   Read your medicines labels and packaging carefully and visit nps.org.au for detailed information about your prescription and pharmacist-only medicines.

5. ASK QUESTIONS ABOUT YOUR MEDICINES
   Be an active partner in your healthcare.
   Ask about the risks and benefits of your medicines.
   Talk to your doctor or pharmacist. visit nps.org.au or call 1300 MEDICINE (1300 634 626)

nps.org.au
Independent, non-profit, evidence-based.
Funded by the Australian Government Department of Health.
MAP Month

- Foyer display
- In-services
- Screensavers
- Posters
- Badges
Are you looking for a perfect match?

Medication matching decreases errors from 213 to 50 per 100 admissions.

Use the MAP form to MATCH UP your medicines.

Improving patient safety by obtaining the best possible medication history and ensuring the right medication the first time!
Standards/Reporting

• Accreditation
  – Med Rec, not just BPMH

• Reportable KPIs
  – MAP facilitates Med Rec

• Clinical Pharmacist standards
  – SHPA, clinCAT

• Forcing functions DO work!
MAP Access

• In ED Admission Pack
  – MAP always with medication chart, enables Issue documentation
• On all wards
• On Pharmacist trolleys
Building a MAPping Culture

• Language
  – “Have you checked the MAP?”
  – “Where’s the MAP?”
  – “Have you written it on the MAP?”
  – “I’ve left you a note on the MAP!”
  – “Document your outcome on the MAP!”

• Admitting doctors now will often request a MAP before charting the NIMC
So after all this, what do our staff actually think?

15 Drs, 23 RNs, 4 CNs & 4 EENs surveyed November 2014

• Results mostly same across disciplines
The information recorded on a MAP that is most useful to my practice is:

- a. BPMH
- b. ADR
- c. Changes
- d. DAAs
- e. GP/NH/CP
- f. DC meds
- g. Designated area to document medication-related issues
• MAP form SIGNIFICANTLY helps to make safe clinical decisions on admission: **97%**
  – On discharge: **79%**

• MAP is referred to **at least once** during admission
  – **32%** of staff stated daily
Who do you think is responsible for the MAP?

- **56%** of staff would contact the ward pharmacist if no MAP

  - a. Doctors
  - b. Pharmacists
  - c. Nurses
  - d. Doctors, Pharmacists, Nursing
  - e. Doctors, Pharmacists
What do you understand to be the main reason/s for med rec?

- MAP is VERY important in minimising/preventing medication errors: **82%**
- MAP helps to make safer decisions: **90%**
- MAP/Med Rec has prevented an error: **59%**
Comments

• “Very useful tool, especially in wards for new grads when meds are not always known”

• “Very useful for us [doctors], but aware that it's a lot of work for you [pharmacists], so thank you”

• “MAPs are good, I depend on them”

• “The MAP is a Godsend”
But despite all this, only pharmacists (and Deb) document BPMH on the MAP

Why is this so?
Medical Officers Documenting BPMH on MAP

- Difficult to sustain

- ‘Another form’
  - Already in progress notes & NIMC
  - Time/workload constraints

- Interrupts flow in progress notes
- 10-12 week rotations & new staff
- Different process from anywhere else
- Seen as a ‘Pharmacy form’
Barriers (2012)

“Need more time and/or more pharmacists!”

“Time is my only barrier…it is a very important part of the patient’s history and ongoing plan”

“The main barrier/s to me contributing to the 'Best Possible Medication History' on the Medication Action Plan (MAP) is/are:

- Time
- Workload
- Confidence
- Other more time-demand...
- Lack of training
- Lack of support
- Lack of feedback on... my performance
- Lack of motivation
- Lack of assistance f...
- It is not a priority for me
- It does not benefit me
- It is another piece of paper
- It is beyond my scope of...
- I have insufficient...
- It does not benefit the...
- It is a waste of my time

Redland Hospital
Barriers (2014)

What are the barriers to completing or recording information on a MAP?

- **b. Time**
- **c. Workload**
- **d. Lack of training**
- **e. Lack of confidence**
- **f. Doesn't benefit my practice**
- **g. Doesn't benefit the pt**

- **Mostly nursing staff**
  - “Educate patients to carry an up-to-date medication list”
  - “Electronically link community and hospital records”
Where to from here?

• Continue using & promoting the MAP
  – Time = Money
  – Continue to improve efficiencies
  – Many hands = light(er) work

• Keep aiming for Utopia where everyone MAPs
How long does it take to form a habit?

- Adjusting to an amputated limb or cosmetic surgery: ~21 days\(^{(1)}\)
- Forming a new habit can take anywhere from 18 days to 254 days\(^{(2)}\)
  - Depending on the behaviour, the person, and the circumstances
- The MAP form…?
  - 9 years? And counting…?

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Thank you

With thanks to all Redland Hospital staff & Metro South Executive that have supported us throughout the project